

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-013674

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3432

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED MAR 28 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION Firmin Desloge Hosp.Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri COUNTYc. CITY
OR
TOWNSt. LouisInside Limits
Yes ☒ No ☐d. STREET
ADDRESS3419 Gasconade St.Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED

First

Middle

Last

(Type or print)

STELLAOLSTEN4. DATE
OF
DEATH

Month

Day

Year

MARCH221963

5. SEX

Female

6. COLOR OR RACE

White7. Married ☐ Never Married ☐Widowed ☒ Divorced ☐

8. DATE OF BIRTH

4-10-1887

9. AGE (last birthday)

75

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Famous-Barr Co.

11. BIRTHPLACE (City and state or country)

Poland

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Martin Lewandowski

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

Frank Olsten (Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Frank Olsten, 2621 Lordan Dr.18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Congestive heart failureINTERVAL BETWEEN
ONSET AND DEATH5 days

DUE TO (b)

Generalized Arteriosclerosis??

DUE TO (c)

Jaundice2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from Mar. 4, 1963 to Mar. 22, 1963 and last saw her alive on Mar. 21, 1963Death occurred at 11:45 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

M.D.

22b. ADDRESS

3654 S. Grand Blvd.

22c. DATE SIGNED

3-25-6323a. BURIAL, CREMATION,
REMOVAL (Specify)Burial

23b. DATE

3-26-1963

23c. NAME OF CEMETERY OR CREMATORY

Calvary Cemetery

23d. LOCATION (City, town, or county)

St. Louis, Missouri

(State)

24. FUNERAL DIRECTOR

ADDRESS

JOHN STYGAR & SON - 5541 RIVERVIEW-BLVD.

25. DATE RECD. BY LOCAL REG.

MAR 25 1963

26. REGISTRAR'S SIGNATURE

Paul Smith, M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF MEDICAL CERTIFICATION DOCUMENT

VS 300
Rev. 4/59

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61

Dr. Cocciolo
3654 S. Grand
Pr. 32414
after 1:00 P.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed *J. M. Roster*

Licensed Embalmer No. 3980

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.